David M. Lintner, M.D.

Phone: 713-441-3560 Fax: 713-790-2054

PATIENT REGISTRATION

Name: (Last)______________________________(First)_________________________(MI)________________

DOB _____/_____/_______ SSN _____-___ _-________ Sex: __________ Marital Status: ___________

Address: ____

City:_________________________________ State: ________ Zip:_____________ Country: ___________

Home phone: ____________________ Work Ph: _______________________ Cell: ______________

May we contact you via email? Y / N E-mail: ____

Employer Name & Address: ____

Occupation:______________________________ Referred by:________________________________

Is this visit due to a Personal Injury Automobile Accident Work Related Injury

Date of Injury_____________

EMERGENCY CONTACT

Name:___________________________________Relationship_________________Phone:________________

INSURANCE (Required for proper billing)

Primary Insurance:____

Subscriber Name:_____________________________________SSN:____-____-______ DOB:___/____/_____

Relationship to Patient: Self Spouse Child Other:_________

ID # _________________________Group #_______________ Benefits Phone_____________________

Secondary Insurance:____

Subscriber Name:_____________________________________SSN:____-____-______ DOB:___/____/_____

Relationship to Patient: Self Spouse Child Other:_________

ID # _________________________Group #_______________ Benefits Phone_____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TMHPO or insurance company to release any information required to process my claims.

Signature of Patient or Guardian_______________________________________ Date____________________